

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2008
NAME OF PROVIDER OR SUPPLIER TWIN OAKS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 SPRINGFIELD DR, CHICO, CA 95928 BUTTE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 23-1991-0004700-F Complaint(s): CA00134448</p> <p>F 323 483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The following violation was identified during an entity self-reported incident visit initiated on 12/10/07. The facility failed to assure that Resident 1 was safe from a harmful accident by not providing adequate supervision after applying a soft restraint. Resident 1 was restrained by a soft waist belt in a wheelchair and subsequently choked to death on her soft waist restraint on 12/07/07. The facility also failed to provide an assistive device (pommel) to keep Resident 1 from sliding beneath the soft waist restraint.</p> <p>Resident 1, a 98 year old female, was admitted on 2/12/07 with diagnoses which included Alzheimer's disease, anxiety state, depressive disorder, general osteoarthritis, debility, failure to thrive-adult, and psychosis. Resident 1's orders included a do not resuscitate (DNR) order.</p>				

Event ID:QL2H11

4/24/2008

11:08:20AM

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	<p>Continued From page 1</p> <p>Resident 1's minimum data set (MDS - a standardized assessment tool) dated 9/25/07, read she had short and long term memory problems and was moderately impaired for decision making. Resident 1 required extensive assist with all aspects of daily living, used a wheelchair for ambulation, was unable to keep her balance while standing without physical support, and was taking Risperdal M (an antipsychotic), Ativan (for anxiety), and Lexapro (an antidepressant).</p> <p>Admission orders, dated 2/12/07, included a soft waist belt in wheelchair due to lack of safety awareness due to dementia.</p> <p>During an interview on 12/10/07 at 2:10 pm, CNA A, a registry CNA, (certified nurse assistant) stated Resident 1 had a soft waist restraint that was crossed at the back of the wheelchair and connected to the bottom bars of her wheelchair. CNA A stated Resident 1 had a habit of slouching toward the back of her wheelchair which caused her to slide down toward the foot of her wheelchair. CNA A stated she and other CNAs assigned to the dining room had repeatedly pulled Resident 1 up in her wheelchair that evening, 12/7/07, to reposition her properly. CNA A stated Resident 1 would slide down in her wheelchair frequently but not as far down or as much as she saw Resident 1 do that evening. CNA A stated since Resident 1 had been sliding so far down in her wheelchair that evening, she and her hall partner, (CNA B, a registry CNA), planned to put Resident 1 in bed right away. CNA A stated she did not work directly with Resident 1</p>				

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	<p>Continued From page 2</p> <p>very often but had seen her several times and was familiar with her being in the dining room for meals.</p> <p>CNA A stated she and CNA B were stopped in the hall on the way to put Resident 1 to bed by a family member of a resident in the room next to Resident 1's room. She stated the family member requested the resident in the room next to Resident 1's room be put in bed first. CNA A stated Resident 1 was in the doorway of her room and had slid down in the seat again and that CNA B pulled Resident 1 up in her wheelchair to reposition her just prior to entering the other resident's room. CNA A stated "both she and CNA B felt Resident 1 would be all right for a few minutes."</p> <p>CNA A stated approximately 20 - 30 minutes later, she and CNA B came out of the room next to Resident 1's room and noticed the door to Resident 1's room was closed. CNA A stated she knocked and entered the room with CNA B and saw Resident 1 lying on the floor at the foot of her wheelchair with the waist belt under her chin and still connected to the back of the wheelchair. CNA A stated she and CNA B removed Resident 1 from the restraint and laid her on the floor. CNA A stated CNA B started CPR (cardio-pulmonary resuscitation) while she called for a nurse.</p> <p>CNA A stated LVN C (licensed vocational nurse) arrived in the room, told both CNA A and CNA B that Resident 1 was a "DNR" and instructed both them to stop CPR. CNA A stated LVN C felt Resident 1's neck for a pulse and listened to her chest with a stethoscope but found no pulse and</p>				

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	<p>Continued From page 3</p> <p>heard no heartbeat. CNA A stated she and CNA B were then instructed by LVN C to place Resident 1 on her bed.</p> <p>Resident 1's record was reviewed on 12/10/07. The records from the previous facility, included in Resident 1's admission records, had a physical therapy evaluation form dated 12/14/06. The physical therapy evaluation identified Resident 1 as wheelchair bound with soft restraint and that she "slides out of wheelchair." Resident 1's admission minimum data set dated 2/21/07, indicated she was self-sufficient in her wheelchair with supervision. Resident 1's quarterly review minimum data set dated 6/28/07 indicated Resident 1's self-sufficiency once in her wheelchair had declined from requiring only supervision to a need for limited physical assistance. Care plan flow sheets for the month of December 2007, included Resident 1 had been provided extensive assistance with the support of one person while in her wheelchair on and off the unit.</p> <p>During a telephone interview on 12/11/07 at 1:20 pm, LVN C stated she had been passing medications when she saw a CNA motioning to her and yelling from down the hallway. LVN C stated when she entered Resident 1's room, CNA A and CNA B already had Resident 1 on the floor and were starting CPR. LVN C stated she could see that Resident 1 was not breathing and when she checked Resident 1 for a pulse by placing her hand against Resident 1's carotid (the major artery in the neck) and listening to Resident 1's chest with her stethoscope, she found no pulse. LVN C stated</p>				

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	<p>Continued From page 4</p> <p>she checked Resident 1's record for a DNR order and told CNA A and CNA B not to do CPR and asked them to place Resident 1 on her bed.</p> <p>During a telephone interview on 12/11/07 at 1:30 pm, CNA B stated she and CNA A noticed Resident 1's door shut, knocked on the door, and went in to put Resident 1 to bed. CNA B stated CNA A saw Resident 1 first and said, "Oh, my God." CNA B stated she moved around CNA A and saw Resident 1 lying on the floor with both arms at her sides and Resident 1's upper body at the shoulders and her head were angled off the floor with the soft restraint holding her chin. CNA B stated both she and CNA A removed Resident 1 from the restraint, yelled for the nurse, and got ready to start CPR.</p> <p>CNA B stated she had pulled Resident 1 up in her wheelchair 2 times that evening and another CNA had pulled her up at least 2 to 3 times while Resident 1 was in the dining room. CNA B stated Resident 1 could not stand during her transfers.</p> <p>During an interview on 12/17/07 at 11:55 am, CNA E stated she knew Resident 1 and had worked with her frequently on the unit. CNA E stated Resident 1 had a pummel cushion on her wheelchair for a long time but its use had been stopped about a month prior to Resident 1's accident. CNA E stated the pummel cushion was discontinued to try and reduce the number of restraints Resident 1 needed. CNA E stated Resident 1 would always slide down in her wheelchair without the pummel cushion.</p>				

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	<p>Continued From page 5</p> <p>During an interview on 12/17/07 at 12:15 pm, LVN G stated she knew Resident 1 slid down in her wheelchair quite often and was concerned enough to have the problem discussed at an interdisciplinary team meeting. Staff G stated the use of the pummel cushion was being discussed but she had not been made aware of any decision prior to Resident 1's accident.</p> <p>During another interview with CNA E on 12/17/07 at 2:40 pm, CNA E stated Resident 1 had a pummel cushion for several months but could not remember exactly when it was started. CNA E stated Resident 1 had slipped so far down in her wheelchair about a week to a week and a half before her accident that the charge nurse thought Resident 1 was going to choke herself that day.</p> <p>During an interview on 1/4/08 at 10:30 am, LVN H stated she observed Resident 1 slumped down in her wheelchair with her waist belt "way up" on her chest. She stated the incident "scared me so bad I wrote for a therapy referral." LVN H stated when she makes a therapy referral she writes it on the daily 24-hour report that is given to administration each morning.</p> <p>During record review on 1/4/08 at 11:20 am, the 24 hour report, dated 12/2/07, revealed an entry was made by LVN H on the night shift for Resident 1. The entry read Resident 1 was up in her wheelchair with a softbelt and "referred to therapy for pumel, keeps sliding forward."</p>				

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	<p>Continued From page 6</p> <p>During an interview on 12/27/07 at 11:15 am, ADM I stated ADM J usually takes the notes for the morning stand-up meeting when the interdisciplinary team goes over the 24 hour nursing report. ADM J stated she did not remember any problems being addressed for Resident 1. ADM J stated LVN H had mentioned that she asked physical therapy to evaluate Resident 1 for her posture.</p> <p>During record review on 12/17/07, an interdisciplinary team progress note dated 3/27/07 at 11:40 am, read Resident 1 was screened by an occupational therapy staff member. The progress note indicated the pummel was appropriate and that a pummel was given to nursing and they would initiate. The idea for the use of a pummel for Resident 1 had been considered as early as March of 2007.</p> <p>Review of the Coroner's report dated 12/12/07, read the medical examiner's preliminary findings were that Resident 1 had "died of asphyxiation due to the wheelchair seatbelt around her head/neck area."</p> <p>The Forensic Autopsy Report dated 1/7/08, read "cause of death was mechanical asphyxiation due to neck compression, due to soft restraint entrapment in wheelchair."</p> <p>The Physician/Coroner's Amendment for working copy of Resident 1's death certificate dated 1/10/08, read cause of death was "mechanical asphyxiation... due to neck compression... due to</p>				

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	<p>Continued From page 7</p> <p>soft restraint entrapment in wheelchair."</p> <p>The facility failed to assure that Resident 1 was safe from a harmful accident by not providing adequate supervision. Resident 1 was restrained by a soft waist belt in a wheelchair, left unattended for 20 to 30 minutes after exhibiting increasing tendencies of sliding down in her wheelchair, and subsequently choked to death on her soft waist belt on 12/07/07.</p> <p>This violation presented, either an imminent danger that death or serious harm would result or substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of the resident.</p>				

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